



## Obesity: The biggest unrecognised public health problem?

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Lifestyle changes resulting from industrialisation are contributing to a rapid rise in diabetes world wide.

Narayan (2001)

### Background

When energy intake exceeds energy expenditure, the excess energy is converted to fat, body weight increases and ultimately obesity ensues. In adults, obesity is defined as a body mass index of 30 kg/m<sup>2</sup> or greater. This simplistic definition suggests that by limiting our food and therefore energy intake to correct the imbalance, obesity will be prevented or reversed. It sounds like a relatively easy task – but in today's society it is not. Eating is so much more than energy intake, it is a highly social, culturally steeped activity controlled by a huge variety of complex factors including genetic predisposition, appetite, our views about the importance of food, where and how we live and many more. The control of obesity is therefore fraught with difficulty as we are only just beginning to understand why it happens and how it can be prevented. Health problems associated with obesity have increased as the prevalence of obesity has risen dramatically over the last 20 years. In the UK one in five adults is now obese.

Obesity and malnutrition are measured using Body Mass Index (BMI), calculated by weight (kg) divided by height (m) squared. Prior to standardisation by the World Health Organisation (WHO) in 1997, international comparisons were difficult due to national variations in interpretation of BMI. Each culture has its own interpretation about where normality begins and obesity starts and normal, overweight and obese are arbitrary classifications on a continuum. WHO standard BMI classification for normal adults is shown in Table 1. However, body builders, babies, adolescents and pregnant women have distorted ratios and do not fit into standard classification systems.

### Levels of obesity in the population

Approximately 300 million people world wide are thought to be obese with the most noticeable increase in the recorded rates of obesity occurring in 'developed countries'.<sup>1</sup>

Obesity is also an increasing problem in developing countries, particularly for the urban dwellers. Improvements in health and average life expectancy resulting from immunisation, reduced risk of infectious diseases and childhood mortality in many poor countries are being stalled by the increasing rates of premature deaths from lifestyle diseases such as diabetes. The World Health Organisation suggests that we are suffering from a world wide epidemic of obesity. International comparisons from 1990 / 91-93 (see Table 2) show that although the prevalence of obesity in England is high, it is still lower than in some other industrialised countries.

A recently conducted Harris Poll released on the 5th March 2002 shows that in the United States of America, 80% of people older than 25 are overweight. This has risen from 71% in 1995, 64% in 1990 and 58% in 1983.

Between 1980 and 1998 the

prevalence of obesity in the UK nearly trebled.

In 1998 in the UK, 17.3% men and 21.2% of women were obese and if current trends continue 25.0% of women and 20.0% of men will be obese by 2005.

In adults over 45 years, two-thirds are now overweight or obese. Obesity is more common in women in lower socio-economic groups, and in some ethnic groups.

Table 1

Classification of obesity and malnutrition according to BMI

Classification	BMI kg/m <sup>2</sup>
Obese Class 3	>40
Obese Class 2	35.0 -39.9
Obese Class 1	30.0 -34.9
Overweight	25.0 -29.9
Normal weight	18.5 -24.9
Underweight	<18.5

Source: World Health Organisation (WHO)

### Working out your own BMI

**Step 1** Work out your height in metres and multiply the figure by itself.

**Step 2** Measure your weight in kilograms

**Step 3** Divide the weight by the height squared (Answer to step 1)

An Example

Height 1.6m (5 feet 3 inches) tall and weigh 65kg (10 stone)

$1.6 \times 1.6 = 2.56$ .

$65 \text{ divided by } 2.56 = \text{BMI } 25.39$

Various web sites can also assist with the calculations in either imperial or metric measurements

77.17 billion pounds was spent on food for consumption at home in 1989 by UK consumers, by 1999 this had risen to 107.47 billion pounds.

Mintel 2000

Table 2

International comparisons of prevalence of obesity

Year of survey	Country	Prevalence (%)	
		Women	Men
1991	United States	24.7	19.7
1990	Germany	19.3	17.2
1991/93	Finland	11.0	14.0
1991	England	15.0	12.7
1990	Netherlands	9.0	7.4

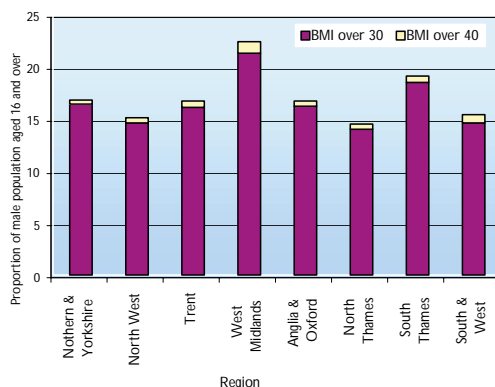
Source: Association for the Study of Obesity (ASO)

### The North West

The prevalence of obesity ranges from 18.0% to 22.0% across the regions in the UK. The age standardised prevalence of obesity for men and women can be seen in Figure 1 and Figure 2.

Figure 1

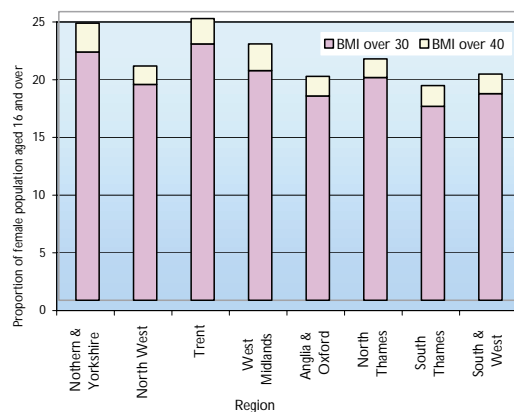
Proportion of male population in each region with obesity (age standardised)



Source: Health Survey for England, 1994 - 1996

Figure 2

Proportion of female population in each region with obesity (age standardised)



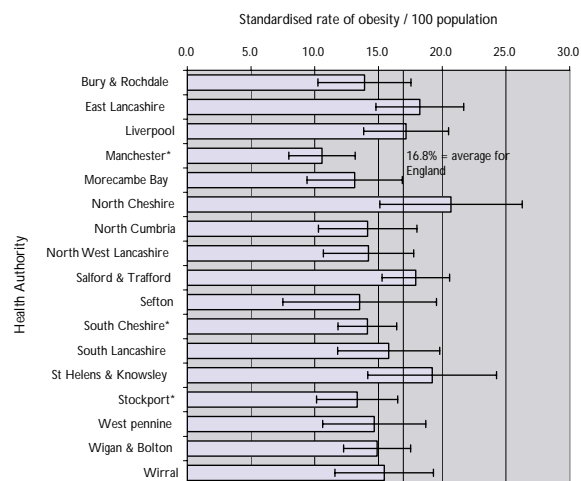
Source: Health Survey for England, 1994 - 1996

Although the North West population does not have significantly higher average prevalence of obesity than the rest of England, it is an important issue for this region because obesity is associated with poverty, and out of the 841 most deprived wards in England, 215 are in the North West. This is double the proportion expected.<sup>2</sup>

Figure 3 shows a breakdown of mean BMI by Health Authority in the North West. The mean standardised obesity rate was 16.8 per 100 adult population in England during 1994-1996. Manchester, South Cheshire and Stockport (marked \*) have estimates that are significantly lower than the English average.

Figure 3

Proportion (%) of the total adult population (age standardised) who are obese (BMI > 30) by Health Authority in the North West with 95% confidence intervals



Source: Health Survey for England, 1994 - 1996

### Obesity is a public health issue

Obesity is associated with increased risk of morbidity and mortality. As well as physical problems, the psychological effects of being overweight or obese can be substantial. Problems include the following (although this is not an exhaustive list).

- Type 2 diabetes
- Coronary heart disease
- Hypertension
- Depression
- Cancers
- Musculoskeletal problems
- High blood pressure
- Stroke
- Respiratory difficulties
- Low self esteem

Excess fat deposited around the abdominal area tends to be associated with greater health risks than fat located in the thighs, or other parts of the body. A waist circumference of more than 32 inches for women and 37 inches for men is associated with an increased risk of morbidity.

### Type 2 diabetes

There is a close link between obesity and Type 2 diabetes. Eighty percent of those with Type 2 diabetes are overweight or obese. Type 2 diabetes is associated with an increased risk of premature death, as well as blindness, kidney, circulatory and nerve problems. Since the onset is often insidious, the average person has diabetes for several years before diagnosis is made and during the intervening years considerable body system damage may occur. Early investigation and treatment is important as it may delay the onset of complications. Recognising the importance of this, the National Institute for Clinical Excellence (NICE) has just issued two clinical guidelines for the management of Type 2 diabetes. They cover screening for and management of eye problems and the prevention and management of kidney disease.

An estimated 135 million people world wide had diagnosed diabetes in 1995, and this number is expected to rise to at least 300 million by 2025. Between 1995 and 2025 the number of people with diabetes will increase by 42% (from 51 to 72 million) in industrialised countries and by 170% (from 84 to 228 million) in industrialising countries.

1.4 million people in this country suffer from diabetes and the median age at diagnosis is about 60, but the entire age distribution curve is shifting to the younger age groups.

Peter Bundred, reader in primary care at the University of Liverpool, found that from 1989 to 1998 there was a highly significant increase in weight and body mass index in children under 4 years of age in children living on the Wirral.<sup>3</sup>

These data herald a further increase in the prevalence of adult obesity and its complications. Type 2 diabetes, which was previously rare in children and adolescents, now accounts for over 30% of new cases in some parts of the United States and most cases of Type 2 diabetes in children and adolescents are attributable to obesity. In the UK Type 2 diabetes has already been found in a few children of Asian and African origin and in early March the first cases of Type 2 diabetes in obese, white adolescents, three girls aged from 13 to 15 and a boy aged 15 were announced.

Earlier age of onset is liable to result in a higher rate of complications such as high blood pressure and blindness and it is predicted that the prevalence of these problems will rise in parallel with the growing rate of childhood obesity.

### Obesity and health inequalities

Unless the dramatic rise in obesity is halted, inequalities in health will increase as the burden of ill health caused by the rising prevalence of obesity and diabetes falls disproportionately on the poor and those from ethnic minorities. There is a highly significant correlation between wards with a high level of deprivation (DETR deprivation index) and age standardised rates of hospital treatments for diabetes related problems in the North West Region (Pearson correlation coefficient = 0.412,  $p < 0.01$ ).

People from Asian, African or Caribbean origins (particularly women) are 3 to 5 times more likely to develop diabetes than are people from a European background.<sup>4</sup> Asians are more likely than Europeans to develop diabetes with comparatively small increases in BMI.

### Other health problems

Obesity increases the risk of osteoarthritis and other disabling musculoskeletal problems that restrict mobility and freedom of movement.

High blood pressure is associated with obesity and increases risk of stroke. The incidence of and mortality associated with stroke in the North West is amongst the highest in the country, with the Health Authority populations of Manchester and Liverpool having the highest age standardised mortality rates for the under 65 year olds in the region.

### What is causing the current epidemic

The reasons why people overeat and take little exercise are highly complex and a wide variety of external influences is in plentiful supply. Dietary and activity habits tend to follow cultural norms, but are always tempered by individual preferences. The international obesity task force (IOTF) of the World Health Organisation has developed a model that illustrates that obesity is not simply caused by 'overeating' and that a complex web of societal influences from the international to the individual level impact on obesity.<sup>5</sup>

### Energy in

#### How much and what we eat

In England, overall calorific intake (self-reported) has not changed dramatically between 1980 and 1998, but there has been a move towards diets that contain higher proportions of fat. The joint health survey for England found that 38.0% of men and 16.0% of women in the 16 to 24 year old age group had diets that were considered to be significantly higher in fat and lower in fibre than recommended levels.<sup>6</sup>

Portion size in pre-packaged food has increased in size over the years. Since much of the cost of pre-packaged items is associated with the

packaging rather than the food itself, it is relatively easy for manufacturers to increase portion size without detriment to profit. Mass production of pre-cooked food and drink is now common, but processed foods are considered less healthy because they contain larger proportions of fat, sugar and salt than most food prepared at home.

#### What is in our food?

You are what you eat – but do you know what you are eating? The move to display sugar, fat, salt and fibre content for pre-cooked items such as pies, pasties and sandwiches is largely driven by European Union legislation, but this information is still not available for all the food that we buy.

Eating out has become an increasingly popular leisure activity and branded fast food chains are ubiquitous. UK consumers have increased spending on eating out from around £17million to just under £21million over the last five years.<sup>7</sup> The lack of labelling and nutrition guidance on restaurant / café food means that making an informed choice about fat and other nutrient intake of food eaten out is impossible.

#### Access to nutritional food

Access to a safe and healthy variety of food was described as 'a fundamental human right' in the first action plan for food and nutrition policy for 2000 – 2005 developed last year by the WHO European Region.<sup>8</sup> Other than for expensive specialist foods, small independent retailers are a rarity.



Among young people aged 4 – 18 years, 59% of girls and 50% of boys said that they ate salad vegetables (and raw vegetables) whilst 4% ate no vegetables at all during the previous week.

Gregory (2000)

The amount of physical activity undertaken during one week is associated with age.

An overall decline in the amount of physical activity undertaken occurs around the age of 35 years.

Department of Health 1999

Large out of town supermarkets that provide increased choice and variety and meet consumers needs have proliferated in recent years, but access to these supermarkets can be problematic for those living in poverty or with limited mobility.

### The media

Commercials aimed at children (and adults) encourage the intake of high fat snack foods and rarely depict consumption of fruit and / or vegetables.

### Energy out

Lack of activity is an important factor in the increasing prevalence of obesity that has occurred especially in the lower socio-economic groups over a period of time when total energy intake and fat consumption actually declined. Dietary surveys indicate that the observed fall in physical activity has not been accompanied by a corresponding reduction in food / energy intake.

Most people in the UK have very inactive lifestyles - few people have physically active jobs or do significant amounts of exercise out of work. Walking or cycling instead of using the car, going to exercise classes and taking part in team sports such as football or basketball instead of watching television or playing computer games are all activities that can help maintain a healthy body weight by increasing energy output.

Over the last few years average adult energy expenditure may have reduced by as much as 30%. The proliferation of private gymnasias may make it seem that we are becoming a more fitness conscious society, but it is the professional classes that are taking up physically active leisure pursuits in far greater numbers than those who live in poverty or come from working class backgrounds. Less than 20% of middle aged and older adults engage in a level of physical activity regarded as sufficient to maintain good health.

In general, active people are slimmer than sedentary people. Men and women who engage in regular physical activity such as walking, running or dancing are less likely to gain weight than inactive individuals. One study shows that the chances of 13kg of weight gain over a 10 year period are 7 times higher in sedentary women than in the active group, whilst sedentary men are 3.9 times more likely to gain 8-13kg than men who report a high level of activity. Men and women who become inactive increase their risk of weight gain.<sup>9</sup>

Levels of activity in children have also fallen. Parents are increasingly fearful of allowing them to play outside or walk or cycle to school. Only 5% of young people use bicycles as a form of transport in Britain, compared to 60-70% in Holland, and 30-40% of children are now taken to school by car compared to 9% in 1971.

English schools are at the bottom of the European league in terms of time allocated to physical education in primary and secondary schools, and school sport has declined in the last decade.

### Treating obesity and its complications

Obese people say that they want to be slim, and it is easy to suggest that they should therefore eat less and exercise more, but if it was that easy more would manage it. It is very difficult for an obese person to return to a normal weight. For the obese individual, a change in lifestyle that combines increased general activity with a healthy, low fat, high fibre diet appears to work best in the long term. Treatments that involve a drastic reduction in food intake do result in rapid, short term weight loss, but they are not sustainable. Unless a healthy diet becomes a part of a change in overall lifestyle, weight lost while on the 'crash' diet quickly goes back on when 'normal' diet and activities are resumed.

But obesity needs to be tackled at the population and international levels, as it is not just an individual issue. The food and the exercise industries together with non-governmental, local, regional and national

g o v e r n m e n t a l organisations all need to be involved in the development of a cross-cutting strategy to encourage the lifestyle changes needed and make the healthy choices the easier choices.

New drugs that tackle obesity at the biological level have been developed in recent years. Obesity

drugs should ideally affect both energy intake and energy expenditure to have a significant and long lasting impact on body weight. Drugs that act purely on one side of the energy balance are unlikely to achieve long-term reduction in body fat because of compensatory adjustments that ensure the maintenance of body fat homeostasis. The use of drugs to tackle obesity is expensive and highly controversial and the National Institute for Clinical Excellence (NICE) recommends that drug therapy for obesity should only be initiated as part of a package of strategies for tackling obesity which should be implemented by appropriately trained primary care staff supported by community dieticians.

The most drastic of obesity treatments - surgery can reduce energy input by limiting the quantity of food held in the stomach or by reducing absorption of digested food. This treatment is also highly controversial and NICE guidelines for obesity surgery are in preparation.

Regular physical activity is very important for people with Type 2 diabetes because of the role skeletal muscle plays in insulin sensitivity and normal fat homeostasis. In one trial, people with diabetes who exercised regularly for three months showed a significant increase in their levels of high-density lipoprotein (good) cholesterol.



This suggests a reduced risk for cardiovascular problems. Every diabetic should know that their health depends on both diet and exercise and that the two are essential and inseparable.

### Costs associated with obesity and its complications

In 1998 on conservative estimates, obesity treatment cost the NHS £0.5 billion and this represents approximately 1.5% of the total NHS expenditure in that year. The bulk of this cost is attributable to treating the consequences of obesity with only £9.5million going on the direct costs of treating obesity itself. A further £2 billion was attributable to society more widely through sickness time off etc.<sup>10</sup> In the year 2000, Diabetes UK estimated that the NHS actually spent £5.2billion treating diabetes and its complications, which represents a huge 9% of the healthcare budget.



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Over 18 million sick days and 6% of all deaths are attributed to obesity each year (compared to about 10% due to smoking) and an obese person loses approximately 9 years of life. If the prevalence of obesity continues to rise at the present rate, until 2010, when it would approach levels of obesity seen in the USA, annual costs would increase by £1billion to around £3.6billion.

### Healthy lifestyle promotion and the prevention of obesity

Treatment costs for obesity and its complications are high and estimates vary, but everyone agrees that if we do not succeed in preventing the spiralling increase in the prevalence of obesity, as a proportion of national health expenditure they will be even higher in the future.

The World Health Organisation suggests that strategies to tackle overeating and under-activity at the individual level have largely been ineffective and that the best way to tackle obesity is to take a more public health approach. The Public Health Approaches to the Prevention of Obesity (PHAPO) working group of the international obesity task force (IOTF) is trying to identify and collate information on programmes in varied settings from all parts of the world - at local, national and international levels, which have either directly or indirectly impacted on population eating and activity patterns. The group plan to share and disseminate examples of effective practice, especially programmes and policies that are relevant to obesity prevention, which address the major societal contributors to over-consumption of food and inadequate physical activity.

Lifestyle intervention programmes have proved successful in preventing the onset of Type 2 diabetes. A randomised trial of 522 middle aged, overweight

people with impaired glucose tolerance carried out in Finland, showed that lifestyle changes can reduce the risk of progression to diabetes by 58% over four years. Each person in the intervention group received individualised counselling aimed at reducing weight, improving diet (by reducing intake of total fat and saturated fat and increasing intake of dietary fibre), and increasing physical activity. The net weight loss at the

end of two years was modest: 3.5 kg in the intervention group and 0.8 kg in the control group. However, the cumulative incidence of diabetes after four years was 11% in the intervention group and 23% in the control group. The reduction in the incidence of diabetes was directly associated with the changes in lifestyle. One case of diabetes was prevented for every five subjects with impaired glucose tolerance treated for five years or for every 22 subjects treated for one year.<sup>11</sup>

In 1980 the Netherlands and the UK had similar rates of obesity, but by 2000 the prevalence in the UK was 50% higher than that in the Netherlands.<sup>12</sup> The Dutch developed a series of policies in order to tackle obesity. This included the development of a central database (accessed via the web) that allowed public health practitioners to input results of studies or interventions that tackled obesity. This facilitated the sharing of information about effective initiatives as well as the co-ordination of activities.

The National Audit Office (NAO) report (February 2001) on tackling obesity in England recommended that:

- The Department of Health should reinforce existing joint working.
- The Department of Health should lead the development of new cross cutting Government strategies and develop and support alternative approaches to the issue of obesity.
- Local targets for walking and cycling should be developed, with incentives to support healthy modes of transportation.
- Departments should work together to support increased participation in sport and physical activity.
- Guidelines for those in general practice should be drawn up to establish a UK protocol for tackling obesity.

Other recommendations focused on the importance of working in partnership with local authorities and other government departments to tackle obesity. Only a few health promotion activities are specifically aimed at preventing overweight and obesity. However, many current activities driven by health priorities identified in 'Saving Lives: Our Healthier Nation' and the Department of Health's 'National Service Frameworks' include prevention of obesity as part of the work on

An average ten year old child eats their own weight in chips over a nine month period.

Haliborange (2000)

With 10% of 6 years olds now classified as obese, there is also a need to focus on the prevention of obesity in children.

the prevention of other problems such as coronary heart disease, stroke, diabetes and cancers. Many non-governmental organisations organise initiatives to prevent and aid weight loss such as; the British Heart Foundation's 'lets get moving' initiative and Sustrans work on improving cycles paths.

The costs of prevention need not be substantial. One organisation found that placing a sign near a lift saying 'use the stairs, help the heart' proved effective at increasing stair usage.

Unfortunately many such seemingly small opportunities for health promotion are missed. Workplace initiatives to encourage exercise and healthy diets are few. How often will you see fruit accessible and affordable in your workplace? Do vending machines offer healthy options?

### Children

With 10% of 6 years olds now classified as obese, there is also a need to focus on the prevention of obesity in children.

Although there is a lack of evidence about the effectiveness of health promotion, many activities that are encouraged because they promote health in other ways such as breast feeding, do also reduce the risk of obesity. The promotion of a family lifestyle that promotes healthy eating patterns such as regular family meals, is a basic intervention that is likely to reduce children's access to foods that are high in fat and is unlikely to produce harm. Reducing the amount of time that children watch television or play computer games also offers children greater opportunity for spontaneous play and may be the only action needed to increase their physical activity. Reduction of contact time with television may also reduce children's demands for the unhealthy food commonly portrayed in advertisements.

The national healthy schools initiative encourages a whole school approach to healthy lifestyles in schools. Suitable obesity prevention activities could include the provision of healthy school food in the dining room as well as the tuck shop and greater opportunities for play or other physical activity during the day.

The national school fruit scheme programme, in which each pre-school child is provided with a piece of fruit each day, encourages the development of a culture of regular fruit consumption rather than high calorie snack foods.

## Tackling obesity in the North West

### The University of Liverpool

The Department of Medicine at Liverpool was the first UK University to create a Chair in Obesity. The post is highly controversial because it is sponsored by the drug company AstraZeneca. Although the post is welcome from the point of view of raising awareness of obesity as an important issue, there is a fear that this appointment will shift the balance of research and subsequent programmes towards the medical treatment of rather than the public health approach to the prevention of obesity. The first appointed Professor is Paul Trayhurn a biochemist and physiologist who amongst other things is looking at the role of white adipose tissue in human fat homeostasis.

### Liverpool John Moores University

Professor David Goldspink, from the Research Institute for Sport and Exercise Sciences, says that the Institute has a new project that plans to examine how the size and function of the heart changes in response to exercise and nutrition and that this could impact on our understanding of obesity and heart disease.

### The Sefton Framework – a way forward?

An obesity strategy working group was formed between Sefton Health Authority and Aintree NHS Trust in 1998. The working group devised an overall framework for action that included:

The epidemiology of obesity and related problems.

An evidence based service framework (using up-to-date evidence available).

A strategy for balanced investment, according to severity and risk of co morbidity.

An approach to evaluation and future service development.

One of the key recommendations was that priority should be given to investment in obesity prevention. This was based on the assumption that without this investment, medical and surgical treatment costs will escalate out of control.

Healthy Living Centres were set up to promote healthy lifestyles and may provide the best framework through which people can access appropriate initiatives for tackling obesity.

### What next?

Only time will tell if we are able to begin to tackle this growing epidemic, a failure to do so however will be catastrophic not only in terms of cost to the NHS, and the wider economy but also in years of life lost and the social consequences of Type 2 diabetes. Whilst the epidemic is huge, especially if the wider consequences of obesity are included, the profile of programmes tackling these issues is still too small.

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# Balancing Life for Health



When Dr Mahmood Adil visits Pakistani villages, he is struck by the absence of osteo-arthritis. While those of us who inhabit these damp, British Isles might feel that joints survive better in warmer weather, Dr Adil has another theory which has implications for all of us.

"I am sure that there is so little osteo-arthritis because people living in Pakistani villages move around a lot and do their work manually. They keep fitter by doing more exercise within the course of their daily lives.

Our highly technological, sedentary western lifestyle is no longer conducive to active daily life. So many of us sit at computers all day long, we drive to and from work and we have a lot of aids to do housework and gardening. Our bodies were fitter and leaner when we moved about more."

As the Regional Public Health Consultant, with responsibility for the implementation of the National Service Framework on diabetes, Dr Adil is concerned about obesity which can trigger diabetes, coronary heart disease, arthritis and other conditions.

Our couch potato, keyboard existence stacks up health problems that cost the National Health Service millions to treat.

"We need to examine our daily lifestyles to see where we could exercise more. I do try to do this, although I need to try harder. For example, I enjoy the half-mile walk to the newsagent every Sunday to collect the newspaper but I don't do it every day. Too often I take the car instead of walking to the bus stop to go into town." Dr Adil makes the point that although slimming and fitness have been fashionable for years, with much promotion in the media, as individuals we need to make the leap from wanting to be fit and slim, to getting ourselves into gear and doing something about it. "With help from health services, local authorities, employers and other organisations, we need to take responsibility for our own health if we want to live well for our natural life span. With some quite simple adjustments to our lives we could all help ourselves become fitter for longer," he maintains.

Dr Adil, who came from Lahore, Pakistan, 12 years ago, worked as a paediatrician before moving into public health and he remains concerned about the food children eat and the need to encourage them to enjoy exercising from an early age. The father of two small children, Abdullah, 6 and Aysha 3, he and his wife, Tanveer, mostly keep fit through caring for their active son and daughter. "Although my wife is much fitter than me," Dr Adil admits. A devout Muslim with a passion for cricket and technology, he probably takes better care of his soul than his body, but he is doing his best to bring the two into balance.

"I am sure that there is so little osteo-arthritis because people living in Pakistani villages move around a lot and do their work manually. They keep fitter by doing more exercise within the course of their daily lives.

## Dates for your diary . . . .

**March 21- International day for the Elimination of Racial Discrimination.**

United Nations [www.unhcr.ch](http://www.unhcr.ch)

**March 24- World TB Day Theme for 2002 is "Stop TB, fight poverty".**

This will be a year-long campaign for detection and treatment of tuberculosis. [www.stoptb.org](http://www.stoptb.org)

**March 31- April 7 Mental Health Action Week.**

The Mental Health Foundation. [www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)

**April 7- World Health Day.**

World Health Organisation [www.who.int/world-health-day/](http://www.who.int/world-health-day/)

**April 8- 14 National Depression Week.**

Depression Alliance [www.depressionalliance.org](http://www.depressionalliance.org)

**April 8- 14 Parkinson's Awareness Week.**

Parkinson's Disease Society of the UK [www.parkinsons.org.uk](http://www.parkinsons.org.uk)

## Web sites

<http://www.iotf.org>  
[http://www.who.int/ncd/dia/dia\\_relatedsites.htm](http://www.who.int/ncd/dia/dia_relatedsites.htm)  
<http://www.diabetic.org.uk/index.htm>  
<http://www.gotravelwise.com>  
<http://www.obesity-online.com>  
<http://www.nhlbi.nih.gov/index.htm>  
<http://www.mindbodysoul.gov.uk/eating/bgh.html>

<http://www.aso.org.uk>  
<http://www.toast-uk.org.uk>  
<http://www.health-start.com>  
<http://www.cycling.org.uk>  
<http://www.dtu.ox.ac.uk>  
<http://www.bmj.co.uk>  
<http://www.nao.gov.uk>

North West  
Public Health  
Observatory

Sue Waller  
Public Health Sector  
Liverpool John Moores  
University  
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Liverpool L3 2AB  
Tel: 0151 231 4181  
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This and previous Bulletins  
are available  
on the  
North West  
Public Health  
Observatory  
web site

<http://www.nwpho.org.uk>

Dear All

Thank you all so much for the wonderful response to the Sexually Transmitted Infections issue. There have been several related articles in the papers and on the radio too during the last few weeks. Don't forget that you can join in with any discussions on current or past topics on-line at [www.nwpho.org.uk](http://www.nwpho.org.uk) and then following the links to the NW Health Bulletin. Enjoy...

The Editor

## News & Views

A summary of current obesity related initiatives from around the Region can be found below. We have not attempted to show all, but a selection of the activities that are ongoing at present. If you would like to share information about what you are doing with others, then please use the forum on the NW Health Bulletin web page <http://www.nwpho.org.uk/asp/bulletin.asp>

**Wirral Health Authority** Results from Wirral's health and lifestyle survey are out. From 1992 to 2001 they showed a rise in overweight people from 31% to 46% and a rise in obesity from 9% to 13%. Thus the need for increased service provision and a strategy. Caroline Jones and Chris Whiteside are currently mapping existing service provisions and will set up a working group to develop a strategy. The strategy will incorporate guidelines for the care and management of the overweight / obesity, including appropriate referral routes as well as health promotion.

**Activity classes** Exercise & Lifestyle Centres run weight management courses, as well as physical activity opportunities for anyone with BMI > 30. Currently over 50% of GP referrals to this scheme are for this reason (equates to over 50 per month on average). At present there are NO waiting lists and people can nearly always be seen within a week.

**Children** A multi-disciplinary team hopes to travel to California during the summer of 2002 to see 'Shapedown' (a programme which has had successful long-term outcomes in relation to obesity for over 20 years). It is a family-based scheme incorporating weight management, and behavioural change. Just for Kids, a school-based overweight prevention scheme is also in operation in the USA. Meetings have been set up for the Wirral team to meet with professionals working in the area of childhood obesity. The team aims to adapt and replicate these programmes as appropriate for Wirral. A briefing paper for other health authorities will be made available. Contact Caroline Jones or Sue Drew on 0151 647 2966.

**Stockport** Stockport PCT have recently appointed Deborah Williams as Food and Health Programme Manager. Her role is to provide the strategic lead on Diet and Nutrition as well as the Obesity and Overweight Reduction sections of the five-year strategy 'Preventing Heart Disease in Stockport'. To partner this, the role of the Community Dietician Service is to be further developed and a review of the Community Development Food Programmes is among her early priorities. Deborah can be contacted at [deborah.williams@stockport-pct.nhs.uk](mailto:deborah.williams@stockport-pct.nhs.uk)

**Examples of good practice from our neighbours** Whilst not within our Region a successful programme aimed specifically at men has been ongoing through North Derbyshire Health's 'Waist Watchers' scheme. The programme that has been running for several years provides courses covering key lifestyle issues to men, often in relation to their workplace. For six months, the men compete in teams in a 'waist loss' league.

More information is available from Paul Boshell at North Derbyshire Health on 01246-231255.

## Events

**10 years of Local Tuberculosis Research: 22nd March 12-3pm.** On display at the Tuberculosis Research and Resources Unit, Cardiothoracic Centre, Broad Green Hospital, Liverpool. All Welcome. Contact Dr Peter Davies on [P.D.O.Davies@liverpool.ac.uk](mailto:P.D.O.Davies@liverpool.ac.uk) or Tel 0151 228 1616

**Renewables Conference: 28th March.** Manchester International Convention Centre. [englandsnorthwest.org](http://englandsnorthwest.org). Contact: 0151 293 0505

**A population perspective to the CHD national service framework: 18th April** Manchester Medical Society. Public Health Grand Rounds, University of Manchester. Contact: [chriss.papas@man.ac.uk](mailto:chriss.papas@man.ac.uk)

**Obesity & Its Management – Training Meeting 25th to 27th June** Association for the Study of Obesity. Burton Manor College, Wirral, Merseyside. Contact: [CAHawkins@compuserve.com](mailto:CAHawkins@compuserve.com) or Tel 020 5803 2042